

**PERSONAL INFORMATION**

ALAN SASSON, D.M.D.

**ABOUT YOU**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

I prefer to be addressed as \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security No. \_\_\_\_\_

Please check:  Male  Female  
 Child  Single  
 Divorced  Married  
 Widowed  Domestic Partnered

Home Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Cell No. \_\_\_\_\_

Home No. \_\_\_\_\_

Work No. \_\_\_\_\_ EXT \_\_\_\_\_

May we contact you at this work phone?  Yes  No

Email address \_\_\_\_\_

We send appointment confirmation through email and text. Please select one or both:  Email  Text

If you do not have either, indicate which number to reach you:  
 \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Who may we thank for referring you to us?  
 \_\_\_\_\_

**EMERGENCY CONTACT**

In the event of an emergency, is there someone you would like us to contact?

Name \_\_\_\_\_

Relation \_\_\_\_\_

Phone No. \_\_\_\_\_

**MEETING PATIENT'S IMMEDIATE NEEDS**

What brings you here today:  Check-up  Problem

Other (Explain): \_\_\_\_\_

Why are you changing dental offices?

Insurance  Location  Schedule  Didn't like

Other (Explain): \_\_\_\_\_

Do you have problems with your teeth now?

Yes  No

If yes, please check:  Hot  Cold  Sweet

Food-Caught  Broken Tooth  Other: \_\_\_\_\_

\_\_\_\_\_

Would you like to speak in private with the doctor about any problems?  Yes  No

**WHAT CONCERNS YOU?**

Discomfort  Cost  Time  Inconvenience

Afraid  Other: \_\_\_\_\_

\_\_\_\_\_

I authorize the release of any information relating to claims filed by **BOSTON SMILE CENTER**.

Signature \_\_\_\_\_

I wish to assign benefits to **BOSTON SMILE CENTER** and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# DENTAL INFORMATION

## PAST DENTAL HISTORY

When was the last time you saw a dentist?

- Less than 1 year    1 to 2 years    3+ Years

Former Dentist \_\_\_\_\_

Office Location \_\_\_\_\_

Last Visit Date \_\_\_\_\_

What treatment did you receive?

- Check-Up    Basic Fillings    Major Dental Work

Was that a comfortable experience?    Yes    No

Why? \_\_\_\_\_

Did you have any treatment that was recommended but not yet completed?    Yes    No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

## COSMETIC DENTISTRY

Would you like whiter teeth?    Yes    No

Is there anything in your smile you would like to change if you could?

- Color    Shape    Position    Straighter

Replace Missing Teeth

Other: \_\_\_\_\_

## HOME CARE AND PERIODONTAL HISTORY

What do you do at home to take care of your oral health?

- Mouthwash    Brush; how often? \_\_\_\_\_  
 Floss; how often? \_\_\_\_\_

Do your gums bleed when you brush and/or floss your teeth?    Yes    No

Are you concerned about?    Bad Breath    Taste

Other; explain: \_\_\_\_\_

\_\_\_\_\_

## ALLERGIES

Please circle if you have any allergies to the following:

Amoxicillin   Anesthetics   Novocaine

Metals/Jewelry   Penicillin   Sulfa

Tetracycline   Aspirin   Codeine

Erythromycin   Latex

Other (explain): \_\_\_\_\_

\_\_\_\_\_

## LIFETIME SMILE PLAN

We will always educate you about the health of your mouth and provide you with treatment options so you can make informed choices. Our mission is to partner with you to ensure a successful plan for attaining and maintaining optimum oral health that will keep you smiling for a lifetime.

## DO YOU HAVE ANY QUESTIONS FOR THE DOCTOR?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# HEALTH INFORMATION

## HEALTH HISTORY

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_

Personal Physicians Name \_\_\_\_\_

Office Location \_\_\_\_\_

Phone No. \_\_\_\_\_

Please list any serious illness that you have been hospitalized for in the last 5 years: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all the medications you are currently taking (include over-the-counter medications):

**Medication**

**Reason**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you taking birth control pills?  Yes  No

Could you be pregnant?  Yes  No

Are you currently nursing?  Yes  No

Have you taken osteoporosis treatment drugs?  Yes  No

Have you ever or are you taking blood thinners?  
 Yes  No

Are you taking any supplements?  Yes  No

## PRE-MEDICATIONS

Antibiotic pre-medication may be necessary if you have had or currently have the following: (Please circle)

1. Prosthetic cardiac valve
2. Previous bout of infective bacterial endocarditis
3. Cardiac transplant patients who have had valvulitis
4. Congenital heart disease excluding mitral valve prolapse
5. Joint replacements

**If you require pre-medication, please indicate what medicine you take?** \_\_\_\_\_

## HEALTH CONDITIONS

Please circle if you have ever had any of the following diseases or medical conditions:

- |   |                              |
|---|------------------------------|
| HIV / AIDS  | Cold Sores / Herpes          |
| Acid Reflux   | Headaches (Severe, Frequent) |
| Migraines   | Hemophilia                   |
| Diabetes  | Snoring / Sleep Apnea        |
| Smoking / Tobacco   | Drug / Alcohol Abuse         |
| Difficulty Breathing                                      | Angina                       |
| Arthritis   | Artificial Heart Valves      |
| Hips or Joints  | Asthma / Hay Fever           |
| Blood Transfusions  | Cancer / Chemotherapy        |
| Congenital Heart Defect                                   | Emphysema                    |
| Gastrointestinal Disorder                                 | Surgeries                    |
| Glaucoma (Narrow Angle)                                   | Hearing-Impaired             |
| Heart Attack  | Heart Murmur                 |
| Heart Surgery   | Anemia                       |
| Hepatitis A B C D   | High / Low Blood Pressure    |
| Liver Disease   | Kidney Problems              |
| Mitral Valve  | Prolapse                     |
| Pacemaker   | Radiation Treatments         |
| Stroke  | Shingles                     |
| Sinus Problems  | Thyroid Problems             |
| Tuberculosis  | Tumor Growth                 |
| Ulcers  | Venereal Disease             |
| Rheumatic / Scarlet Fever                                 |                              |
| Alzheimer's / Memory Loss                                 |                              |
| Stents Placed in Heart (Date _____)                       |                              |
| Epilepsy/ seizures/Fainting (Date last episode: ( _____ ) |                              |
| Other (s): _____  |                              |

I hereby certify that the information I have given here today is correct to the best of my knowledge.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# BOSTON SMILE CENTER CONSENTS



## CONSENT FOR DENTAL TREATMENT

1. I authorize the doctor or designated staff to take x-rays and/or use any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of my dental condition and needs.
2. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon.
3. I agree to the use of anesthetics and/or other medications as necessary. I fully understand that utilizing anesthetics entails certain risks. I understand that I can ask for a complete description of any possible complications.
4. I agree to have BOSTON SMILE CENTER share my dental and medical information with other specialists as necessary for my treatment.
5. I agree to keep my reserved dental appointments. If I must cancel an appointment, I agree to give at least 2 business days notice or a cancellation charge may apply.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT FOR USE OF PHOTOS

In consideration of One Cent of a Dollar (\$0.01), receipt of which is acknowledged, I do hereby give BOSTON SMILE CENTER- Alan Sasson, D.M.D. the irrevocable right to use my name, pictures, portraits or photograph in all forms and media and all manners for advertising, trade, or other lawful purpose, and waive any right to inspect or approve the finished product, including written copy, that may be created therewith. I am of legal age.

In signing on behalf of a minor, or myself, I have the legal authority to execute the above release. I have read this release and I consent to its terms.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## FINANCIAL DISCLAIMER

I agree to unconditionally pay for services rendered, irrespective of payment by insurance carriers, workers' compensation and the like. I also agree to pay for services at the time they are rendered unless other arrangements have been made with the financial coordinator in advance. I understand that financial charges may be added to my account for delinquent payments. I understand that there can be no guarantee of outcome with my dental procedure and acknowledge no guarantee has been made to me with regard to the procedures I have authorized. I further acknowledge that I have been given full opportunity to discuss the matters contained herein with J. Alan Sasson, D.M.D., his associates or assistants and that I understand the information provided.

Signature \_\_\_\_\_ Date \_\_\_\_\_